Mary J. Forbes, MD, PLLC
INTERNAL MEDICINE

Compassionate Primary Care You Can Trust

Medical Records Request/Release Form

Chart Number (to be filled in by practice): _____

Patient Name: _____ Date of Birth: ____ /____ /____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

I authorize Mary J. Forbes, MD, PLLC to **release / receive** (circle ONE) the information in my patient record as directed below:

- Provider or organization **to / from** (circle ONE) whom disclosure is to be made:

Name of Provider/Practice: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

- **Reason for Request:**

◯ Moving out of the area ◯ Second Opinion ◯ Legal
◯ Continuation of Care ◯ Personal ◯ Insurance Coverage

- **Dates of service for request:**

◯ All Dates
◯ Date Range: _____ to _____

I **do / do not / not applicable to me** (circle ONE) authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above may be re-disclosed.
- There may be a charge for the requested records per NC General Statute § 90-411.

Patient or Parent/Legal Guardian Signature: _____Date: _____

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